U.S. Department of Health and Human Services

HRSA

Health Resources and Services Administration

HEALTH CENTER PROGRAM UPDATE

DATE: November 8, 2013

DOCUMENT TITLE: Look-Alike Annual Certification Application Instructions

TO: Health Center Program Look-Alikes
Primary Care Associations
Primary Care Organizations
National Cooperative Agreements

The Health Resources and Services Administration (HRSA) is committed to improving the health of underserved communities and vulnerable populations. Health Center Program look-alikes maintain a critical role in supporting the delivery of comprehensive, culturally competent, quality primary health care services to low-income, underserved, and special populations.

Enclosed are the revised annual certification application instructions. This document supersedes all previous annual certification instructions. All look-alike applications must be submitted electronically via HRSA's Electronic Handbooks (EHB). Applications begun in the HRSA EHB on or after January 1, 2014, are required to comply with the application instructions contained herein.

HRSA is committed to providing technical assistance in the preparation of applications. Applicants that seek technical assistance in preparing a look-alike annual certification application may submit questions in writing to the organization's assigned Project Officer, State Primary Care Association (PCA), and/or Primary Care Office (PCO) for assistance in developing an application. Contact information for the State PCAs and PCOs are available on HRSA's Web site at http://bphc.hrsa.gov/technicalassistance/.

James Macrae
Associate Administrator for Primary Health Care

Attachments

U.S. Department of Health and Human Services
Health Resources and Services Administration

Bureau of Primary Health Care

Health Center Program

Look-Alike Annual Certification Application Instructions

Release Date: November 8, 2013

All applications started in the HRSA Electronic Handbook (EHB) on or after the release date must adhere to the instructions contained herein.

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http://bphc.hrsa.gov/about/lookalike/index.html

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LOOK-ALIKE ANNUAL CERTIFICATION PURPOSE AND BACKGROUND

Purpose

The annual certification application will be used by the Health Resources and Services Administration (HRSA) to assess progress, as well as any significant change(s) to a look-alike organization's approved Health Center Program designated activities. The continuation of look-alike designation will be based on compliance with applicable statutory and regulatory requirements, including the timely submission of the annual certification application through the HRSA Electronic Handbook (EHB), demonstrated organizational capacity to accomplish the project's goals, and a determination that continued designation would be in the best interest of the government.

All applicants are expected to demonstrate compliance with the requirements of section 330 of the Public Health Service (PHS) Act, as amended and applicable regulations. Look-alikes are encouraged to refer to http://www.bphc.hrsa.gov/about/requirements/index.html for additional information on key Health Center Program requirements.

Terminology

For the purposes of this document, the term "health center" refers to the following four types of health centers and does not distinguish between Health Center Program look-alikes or grantees.

- Community Health Center (CHC) (section 330(e)),
- Migrant Health Center (MHC) (section 330(g)),
- Health Care for the Homeless (HCH) (section 330(h)), and
- Public Housing Primary Care (PHPC) (section 330(i)) authorized under the PHS Act, as amended

Look-alikes have been historically referred to as Federally Qualified Health Center (FQHC) Look-Alikes. This document will refer to "look-alikes" to underscore that Health Center Program look-alikes are health centers that "look like" Health Center Program grantees that do not receive a Section 330 grant and that they are part of the health center community recognized by Centers for Medicare & Medicaid Services (CMS) as FQHCs.

Legislative Authority

The Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993 amended section 1905 of the Social Security Act (SSA) to create and define a category of facilities under Medicare and Medicaid known as FQHCs. One of the definitions of an FQHC as set forth in section 1861(aa)(4) and section 1905(l)(2)(B) of the SSA is an entity, which is determined by the delegated HHS authority to meet the requirements of the grant program authorized by section 330 of the PHS Act (the Health Center Program, 42 U.S.C. 254b), but does not receive a grant under section 330. This category of health centers has been labeled, "look-alikes." Look-alikes do not receive section 330 grant funding; however, look-alike designation qualifies entities for benefits such as (1) Medicaid and Medicare FQHC payment methodologies; (2) participation in

the 340B Federal Drug Pricing Program; and (3) automatic Health Professional Shortage Area (HPSA) designation. Look-alikes are not eligible for Federal Tort Claims Act medical malpractice liability insurance coverage.

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) modified the look-alike definition under section 1905 of the SSA by adding the requirement that the "entity may not be owned, controlled or operated by another entity." HRSA, in collaboration with the CMS, issued PIN 1999-09, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities," issued April 20, 1999, and PIN 1999-10, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities," issued April 20, 1999, to implement the BBA requirements for public entities and private nonprofit organizations. These documents describe the statutory limits on the involvement of "another entity" in the ownership, control, and/or operation of a public or private nonprofit look-alike. Applicants should work closely with HRSA if there are questions about the application of these policies before submitting an annual certification application.

PROGRAM NARRATIVE REQUIREMENTS

The Program Narrative update should address broad issues and changes that have impacted the community/target population(s) served and the organization, the extent to which the organization's project plan continues to address the specific program requirements, and the organization's progress in meeting the goals of the project plan as stated in the most recently approved look-alike initial designation or renewal of designation application.

Look-alikes must describe current status and any changes to the elements presented in the criteria, including all appropriate health center type-specific elements. Failure to clearly address the requested information could result in a delay of HRSA's review.

Look-alikes **must** use the Program Narrative to discuss the extent to which they continue to meet program specific requirements and provide plans to address any noted deficiencies. HRSA encourages look-alikes review http://www.bphc.hrsa.gov/about/requirements/index.html for information on key Health Center Program requirements.

The Program Narrative update must be consistent with the information presented in the Clinical and Financial Performance Measures Forms and other forms and attachments. The Program Narrative should reference required attachments and forms, as needed, to reflect information about multiple sites and/or geographic or demographic data. The forms and attachments must augment, not replace, required narrative. Look-alikes should use the prescribed section headings and sub-headings below:

NEED

1. **Target Population and Service Area**. Report the CURRENT STATUS and describe any CHANGES since the last application in the target population and service area that affect access to primary health care, health care utilization, and health status. Look-alikes that are not designated to serve migratory and seasonal agricultural workers (section 330(g)), people experiencing homelessness (section 330(h)), and/or residents of public housing (section 330 (i)), but currently serve or may serve these populations in the future, are encouraged to discuss the unique health care needs of these populations.

2. **Special Populations**. For look-alikes that are designated to serve special populations, report the CURRENT STATUS and describe any CHANGES in the following areas, including increases or decreases in the special populations in the service area.

   (a) **Migratory and Seasonal Agricultural Worker (section 330(g)):** Report the CURRENT STATUS and describe any CHANGES in the factors (e.g., access barriers, past utilization) related to the health care needs and demand for services of migratory and seasonal agricultural workers, including:
   - Agricultural environment (e.g., crops and growing seasons, need for labor, number of temporary workers);
   - Approximate period(s) of residence of migrant workers and their families; and
   - Migrant occupation-related factors (e.g., working hours, housing, sanitation, hazards including pesticides and other chemical exposures).

   (b) **People Experiencing Homelessness (section 330(h)):** Report the CURRENT STATUS and describe any CHANGES in the specific health care needs and access issues impacting people experiencing homelessness (e.g., number of providers treating homeless individuals, availability of homeless shelters and/or affordable housing).

   (c) **Residents of Public Housing (section 330(i)):** Report the CURRENT STATUS and describe any CHANGES in the health care needs and access issues impacting residents of public housing (e.g., availability of public housing).

3. **Primary Health Care Services**. Report the CURRENT STATUS and describe any CHANGES in the primary health care services (including behavioral and oral health) currently available in the service area, including any gaps in service (e.g., provider shortages) and the role and location of other providers who currently serve the target population.

4. **Health Care Environment**. Report the CURRENT STATUS and describe any CHANGES in the health care environment that have affected the look-alike's ability to provide services, the target population's ability to access health care, and/or the look-alike's fiscal stability. Topics to be addressed include:

(a) Changes in insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP). Specifically discuss changes that could result from the Affordable Care Act implementation.
(b) Changes in State/local/private uncompensated care programs; and
(c) Changes in the economic or demographic environment of the service area (e.g., influx of refugee population; closing of/changes to local hospitals, community health care providers, or major local employers; major emergencies such as hurricanes, flooding, terrorism).

RESPONSE

1. **Response to Changes**. Report the CURRENT STATUS and describe any CHANGES made since the last application in response to the issues identified in the NEED section.

2. **Change in Scope**. Describe the outcome of any change(s) in scope since the last application including the date when the change in scope was approved. Specifically address reasons for/results of any CHANGES in the:
(a) Locations where services are provided
(b) Hours of operation.

Discuss how these changes continue to assure that services are available and accessible at locations and times that meets the needs of the target population.

3. **Accessibility and Service Delivery**. Report the CURRENT STATUS and describe any CHANGES in the accessibility and/or availability of primary health care services for all life cycles without regard to ability to pay. Changes made to the mode of service delivery in the past year via the EHB scope module (direct vs. formal referral; shifts between any columns on Form 5A) must be described. Specifically address reasons for and results of any CHANGES in the clinical operations and patient care services made as a result of organizational or community changes, including:
(a) Provision of required and additional clinical and non-clinical services, including whether these are provided directly or by referral. REMINDER: All services provided via formal written referral arrangements currently recorded in scope (third column of Form 5A) must meet the requirements outlined in Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes (http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html). For any required service(s) provided ONLY via referral (only the third column of Form 5A), include a narrative statement that a formal written referral arrangement is in place for each such service.
(b) How services are culturally and linguistically appropriate (e.g., availability of interpreter/translator services, bilingual/multicultural staff, training opportunities);
(c) Arrangements for admitting privileges for health center physicians at one or more hospitals to ensure continuity of care, discharge planning, and patient tracking among providers;
(d) Professional coverage during hours when the health center is closed; and

(e) Referral relationships for additional health services and specialty care with other health care providers with an emphasis on working collaboratively to meet local needs.

4. **Clinical Staffing**. Report the CURRENT STATUS and describe any CHANGES in the clinical team staffing plan, including the number and mix of primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, oral health providers, behavioral health professionals, social workers, and other providers, as well as clinical support staff necessary for:
   (a) Providing services for the projected number of patients (consistent with Form 1A),
   (b) Carrying out required preventive, enabling, and additional health services as appropriate and necessary, either directly or through established arrangements and referrals.

5. **Contracts and Formal Referral Arrangments**. Report the CURRENT STATUS and describe any CHANGES in, contracts for a substantial portion of the operation of the health center, and/or other agreements between the look-alike and an outside organization, including any change in oversight and authority to assure compliance with Health Center Program requirements. For any required services provided via referral for which the look-alike does not pay (third column of Form 5A), the look-alike must document that a formal written arrangement/agreement is in place for each such service per Policy Information Notice 2008-01, Defining Scope of Project and Policy for Requesting Changes (http://www.bphc.hrsa.gov/policiesregulations/policies/pin200801.html). For new or revised arrangements, contracts, and/or agreements, include a summary of the agreements in Attachment 3: Affiliation, Contract, and/or Referral Agreements.

   NOTE: All contracts and Memorandums of Agreement or Understanding (MOAs/MOUs) must be kept on file at the look-alike organization and must be made available to HRSA upon request within 3-5 business days. Do not include these items with the annual certification submission.

6. **Special Populations. Migrant Health Center (section 330(g)), Health Care for the Homeless (section 330(h)) and/or Public Housing Primary Care (section 330(i)):** Report the CURRENT STATUS and describe any CHANGES in formal arrangements with other organizations that provide services or support to the special population(s) served (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).

7. **Sliding Fee Discount Scale**. Report the CURRENT STATUS and describe any CHANGES in the system used to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay, including any changes or updates to the established schedule of charges and its corresponding schedule of discounts which ensure that no patient will be denied services due to an inability to pay. Provide the current sliding fee discount schedule(s) in Attachment 8.

8. **Quality Improvement/Quality Assurance**. Report the CURRENT STATUS and describe any CHANGES in the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s). Specifically, address any changes or progress in the following areas:
   (a) The clinical director's responsibility in supporting the quality improvement/assurance program and the provision of high-quality patient care;
   (b) Periodic assessment of the appropriateness of service utilization, quality of services delivered, and the health outcomes of health center patients; and
   (c) How the findings of QI/QA assessments have been used to improve organizational performance and what formal institutional mechanisms/processes are in place to ensure this occurs.

9. **Board-Approved Policies**. Report the CURRENT STATUS and describe any CHANGES in board-approved policies and procedures related to:
   (a) Clinical standards of care,
   (b) Provider credentials and privileges,
   (c) Risk management procedures,
   (d) Patient grievance procedures,
   (e) Incident management, and
   (f) Confidentiality of patient records.

10. **Strategic Plan**. Report the **CURRENT STATUS** and describe any **CHANGES** in the health center's short- and long-term strategic plans and how community needs as well as data from the look-alike's performance improvement systems (e.g., Clinical and Financial Performance Measures, patient satisfaction findings, QI/QA assessments) have been used to inform the strategic planning process.

11. **Anticipated Changes**. Describe any PROPOSED CHANGES being considered for the UPCOMING certification period in services, service sites, provider types, and/or hours of operation based on ongoing strategic planning.

NOTE: No change in scope or self-update is allowed in the annual certification submission; all changes must be completed in accordance with Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes (http://www.bphc.hrsa.gov/policiesregulations/policies/pin200801.html). Additionally, Look-alikes are encouraged to review Program Assistance Letter 2013-03: Alignment of EHB Change in Scope Module with Change in Scope Policy at http://www.bphc.hrsa.gov/policiesregulations/policies/pal201303.html for information regarding updates and enhancements to the Health Center Program Change in Scope (CIS) module of the HRSA's Electronic Handbooks (EHB) system.

12. **Maximizing FQHC Benefits**. Report the CURRENT STATUS and describe any CHANGES in the organization's ability to:

(a) Maximize FQHC-related benefits (e.g., FQHC Medicare/Medicaid/CHIP reimbursement, 340B Drug Pricing Program, Vaccines for Children Program, National Health Service Corps Providers).

13. **Budget.** Report the CURRENT STATUS and describe any SIGNIFICANT CHANGES, referencing the budget as needed, that have impacted:
(a) The maximization of reimbursement from third party payors (e.g., Medicare, Medicaid, CHIP, private insurance) and how this relates to any SIGNIFICANT CHANGES in the patient and payor mix and/or number of projected patients and visits.

COLLABORATION

1. **Formal and Informal Collaboration**. Report the CURRENT STATUS and describe any CHANGES in both formal and informal collaboration and coordination of services with other health care providers. Specifically discuss collaboration with existing health centers (grantees and look-alikes), rural health clinics, hospitals, other federally-supported grantees (e.g., Ryan White programs), State and local health departments, private providers, and programs serving the same target populations (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups).

   Review Program Assistance Letter 2011-02, Health Center Collaboration available at http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html for additional information on maximizing opportunities to collaborate with other health care safety net providers.

2. **New or Revised Collaboration**. Provide evidence of NEW or REVISED collaborations by providing letters of support, commitment, or investment that reference the specific collaboration and/or coordinated activities.

EVALUATIVE MEASURES

1. **Clinical Performance Measures.** Describe PROGRESS made on each of the Clinical Performance Measures identified in the most recent application in the Progress toward Goal and Comments fields of the Clinical Performance Measures forms. Do not repeat information previously provided; instead, discuss overall progress with regard to each performance measure goal. Specifically, look-alikes must:
(a) Discuss progress toward the goal identified for each Clinical Performance Measure, and
(b) Describe contributing and/or restricting factors that impacted progress toward the goal identified for each Clinical Performance Measure.

   Include any information that exceeds the 1,000 character limit of the Comments field in this section of the Program Narrative.

2. **Financial Performance Measures.** Describe PROGRESS made on each of the Financial Performance Measures identified in the most recent application in the Progress toward Goal and Comments fields of the Financial Performance Measures forms. Do not repeat

information previously provided; instead, report and discuss overall progress with regard to each performance measure goal. Specifically, look-alikes must:

(a) Discuss progress toward the goal identified for each Financial Performance Measure, and

(b) Describe contributing and/or restricting factors that impacted progress toward the goal identified for each Financial Performance Measure.

Include any information that exceeds the Comments field's 1,000 character limit in this section of the Program Narrative.

RESOURCES/CAPABILITIES

1. **Organizational Structure.** Report the CURRENT STATUS and describe any CHANGES to the organizational structure of the health center (i.e., changes that affect the budget or scope of project[1]), including any NEW or REVISED affiliation agreements/arrangements. Reference Attachment 4: Organizational Chart and Attachment 3: Affiliation, Contract, and/or Referral Arrangements as applicable.

2. **Management Team.** Discuss any KEY MANAGEMENT STAFF CHANGES or vacancies in the last year, and describe plans for filling these vacancies. Key management positions include chief executive officer (CEO), chief clinical officer (CCO), chief financial officer (CFO), chief information officer (CIO), and chief operating officer (COO). Specify how long each key management position has been vacant and if a temporary/interim person has been assigned. Reference Attachment 5: Position Descriptions for Key Management Staff and Attachment 6: Resumes for Key Management Staff as needed.

3. **Recruitment Plan.** Report the CURRENT STATUS and describe any CHANGES to staffing plans, as well as any contributing or restricting factors encountered during the designation period for recruiting and retaining key management staff and/or health care providers.

4. **Electronic Health Records.** Report the CURRENT STATUS and describe any CHANGES in the acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use. More information about meaningful use is available at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.

5. **Financial Information Systems.** Report the CURRENT STATUS and describe any CHANGES to the organization's financial management capabilities, accounting and control systems, policies, and procedures that have impacted the organization's financial status, as well as actions taken to address adverse trends, including:

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[1] Changes in scope requiring prior approval MUST be submitted through HRSA's Electronic Handbook (EHB). Refer to Policy Information Notice 2008-01, Defining Scope of Project and Policy for Requesting Changes available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

(a) Actions taken to address adverse financial trends in areas such as expenses, revenue, operating deficit, debt burden, or cash flow.

(b) Changes to financial information systems available for collecting, organizing, and tracking key performance data utilized for supporting management decision making and reporting the organization's financial status (e.g., visits, revenue generation, aged accounts receivable by income source or payor type, aged accounts payable, lines of credit, debt to equity ratio, net assets to expenses, working capital to expenses).

6. **Collections and Reimbursement.** Report the CURRENT STATUS and describe any CHANGES to systems in place to maximize collection of payments and reimbursement for services, including policies and procedures for eligibility determination, billing, credit, and collection.

7. **Corrective Actions.** Report the CURRENT STATUS and describe any CHANGES related to corrective actions taken to address any findings, questioned costs, reportable conditions, material weaknesses, and significant deficiencies cited in the most recent audit.

8. **Emergency Preparedness.** Report the CURRENT STATUS and describe any CHANGES related to the development and implementation of an emergency preparedness and management plan, including participation in drills or exercises and participation or attempts to participate with State and local emergency planners.

GOVERNANCE
NOTE: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups, should respond to ONLY Item 5 below.[2]

1. **Board Authority.** Provide a copy of the health center's signed and dated bylaws in Attachment 2 ONLY if these have been revised since the organization's last application. Discuss the type and purpose of all revisions.

2. **Board Composition.** Report the CURRENT STATUS and describe any CHANGES to the composition of the governing board using Form 6A: Current Board Member Characteristics. Provide reasons for changes in terms of size, expertise, non-patient board member income from the health care industry, and representativeness of the service area/target population and special populations[3] served.

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[2] Health Center Program governance requirements do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act.

[3] A look-alike that is currently designated to serve general community (CHC) **AND** special populations (HCH, MHC, and/or PHPC) must have appropriate representation on the board from these populations. At minimum, there must be at least one representative from each of the special population groups for which the organization is designated. Special population representatives should be individuals that can clearly communicate the needs/concerns of the target population and represent this population on the board.

3. **Board Operations.** Report the CURRENT STATUS and describe any CHANGES made to resolve issues in the following areas:
   (a) Meeting monthly;
   (b) Maintaining a 51 percent consumer/patient majority, as applicable;
   (c) Exercising required oversight responsibilities and authorities (e.g., selecting, evaluating, and dismissing the CEO/Executive Director; establishing hours of operation; approving annual budget; conducting board self-assessment);
   (d) Training new and existing governing board members;
   (e) Evaluating board performance (i.e., processes developed for addressing board needs/challenges, including training needs, communication issues, and meeting documentation); and
   (f) Using health center performance trend data that is consistent with the Clinical and Financial Performance Measures to inform strategic planning, support ongoing review of the health center's mission and bylaws, evaluate patient satisfaction, review monthly financial and clinical performance, and update sliding fee discount schedule(s).

4. **Governance Waiver.** Look-alikes that are not designated under Community Health Center (section 330(e)) and have an approved waiver for the 51 percent consumer/patient majority must provide an update on the status of their alternative mechanism and discuss how the mechanism continues to meet the intent of the statute by ensuring consumer/patient representation.

   NOTE: An approved waiver does not relieve the health center's governing board from fulfilling <u>all other board authorities and responsibilities required by statute</u>.

5. **Tribal Groups.** HEALTH CENTERS OPERATED BY INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS: Describe the governance structure and how it will assure adequate (1) input from the community/target population on health center priorities and (2) fiscal and programmatic oversight of the project.

IMPACT
1. **Scope of Project.** Describe PROGRESS made toward the projected number of patients to be served by the end of the designation period compared to the baseline number of patients presented in the most recent application. The projected number of patients to be served by the end of the designation period must be consistent with the number presented on Form 1A: General Information Worksheet. Specifically, look-alikes must discuss:
   (a) Any contributing or restricting factors affecting the achievement of the goal. Reference the growth in patients noted in Form 1A in the Number at End of Designation Period column of the Patients and Visits by Population Type table;
   (b) Look-alikes that currently designated to serve migratory and seasonal agricultural workers (section 330(g)), people experiencing homelessness (section 330(h)), and/or residents of public housing (section 330(i)) MUST discuss reasons for any decrease in the special populations served (e.g., large group of migrant workers no longer working in the service area); and

(c) Look-alikes that have added any service sites during the within the last year must identify progress made toward any proposed increase in patients, visits, providers, and/or services. Discuss any contributing or restricting factors.

REQUIRED FORMS, DOCUMENTS, AND ATTACHMENTS

The annual certification application is a progress update and cannot be used to make any changes in the scope of the approved project. These changes can be made anytime during the year, using the current prior approval requests process within EHB. Failure to submit all required components as outlined in the table below may result in a delay of HRSA's application review.

Required Forms and Documents

The forms and documents indentified in the following table are required submissions (unless noted otherwise). Applicants complete "forms" online using HRSA's EHB. Forms do not need to be downloaded or uploaded. Applicants create "documents" or download them using the template provided in EHB and then upload them into the EHB system or created off line and uploaded to the EHB (e.g., the Abstract and the Program Narrative). ***For detailed instructions for all forms, see Appendix A. PDF versions of all forms are available at*** http://bphc.hrsa.gov/about/lookalike/index.html***.***

Required Documentation	Type	Description	Instructions
Cover Page (Required)	Form	Provides a summary of information related to the project at the time of application submission.	Appendix A
Form 1A: General Information Worksheet (Required)	Form	Provides a summary of information related to the applicant, service area, target population, provider information, and patient visits by service type.	Appendix A
Program Abstract (Required)	Document	Provides a narrative summary of the project.	Program Abstract section
Program Narrative (Required)	Document	Provides a current status and any changes to the designated project. The narrative should complement and align with all information provided in other forms, documents, and attachments.	Program Narrative section
Clinical Performance Measures (Required)	Form	Provides progress made on clinical performance measures.	Appendix A
Financial Performance Measures (Required)	Form	Provides progress made on financial performance measures.	Appendix A

Required Documentation	Type	Description	Instructions
Form 2: Staffing Profile (Required)	Form	Reports personnel salaries supported by the total budget for the next year of the certification period. Current clinical staff must be described within the Program Narrative (6.a.).	Appendix A
Form 3: Income Analysis Form (Required)	Document	Projects program income, by source, for the next year of the certification period.	Appendix A
Form 3A: FQHC Look-Alike Budget (Required)	Form	Reports program budget, by program, function, and activity for the next year of the certification period.	Appendix A
Form 5A: Services Provided (Read Only)	Form	This form is pre-populated with the services in the current approved scope of project. This is a read-only form and may not be modified. *NOTE: Only existing services in the approved scope of project will be pre-populated in the application in the EHB (excluding pending applications for change in scope to add a service).* Only one form is required for all of the required and additional services provided by the look-alike organization.	Appendix A
Form 5B: Service Sites (Read Only)	Form	Identifies details of each service delivery site. This form will be pre-populated with the sites in the current approved scope of project. **No changes can be made.**	Appendix A
Form 5C: Other Activities/Locations (as applicable)	Form	This form is pre-populated with the other activities in the current approved scope of project. This is a read-only form and may not be modified.	Appendix A
Form 6A: Current Board Member Characteristics (Required)	Form	Provides information about governing board member characteristics, including area of expertise and whether the member is a patient of the health center.	Appendix A
Form 8: Health Center Agreements (as applicable)	Form	Provides information about contracts and other agreements that constitute a substantial portion of the scope of project. *Form 8 is approved for the length of the designation period.*	Appendix A
Form 10: Annual Emergency and Management Preparedness Report (Required)	Form	Provides information about the organization's status of emergency preparedness planning and progress toward implementing an emergency management plan. Any "No" responses must be explained in the Project Narrative.	Appendix A
Form 12: Contacts Information (Required)	Form	Identifies organizational contacts for ongoing communication with HRSA.	Appendix A

Required Attachments

Below is a brief overview of required attachments. Attachments are created by the applicant and are then uploaded to the EHB. *For detailed instructions and requirements for Attachments, see Appendix B.*

Required Attachment	Description
Attachment 1—Service Area Map (Required)	A map that clearly identifies the areas served by the organization, all service delivery sites, the designated MUA/MUP areas, census tracts, zip codes, and the location of other primary care provider sites (e.g., section 330-funded health centers, look-alikes, hospitals, free-clinics, etc.).
Attachment 2—Governing Board Bylaws (as applicable)	Describes the authorities and responsibilities of the governing board.
Attachment 3—Affiliation, Contract, and/or Referral Agreements (as applicable)	Provides a brief summary of current contracts and agreements (e.g., contracted provider and/or staff, management services contracts, formal referral arrangements, etc.).
Attachment 4—Organizational Chart (as applicable)	Provides a graphic depiction of the organizational and management structure and lines of authority, key employee position titles, names, and full-time equivalents.
Attachment 5—Position Descriptions for Key Personnel (as applicable)	Provides detailed information about each key personnel position.
Attachment 6—Resumes for Key Personnel (as applicable)	Resumes for all key personnel in the organizational chart.
Attachement 7— Most Recent Independent Financial Audit (Required)	A copy of the organization's most recent independent financial audit and management letter, if applicable.
Attachement 8— Schedule of Discounts/Sliding Fee Scale (Required)	Documentation of the organization's sliding fee scale for patients under 200% of the Federal poverty level (FPL), in accordance with the most recent FPL.
Attachment 9—Budget Narrative (Required)	Upload the Budget Justification in the Budget Narrative Attachment Form field.
Attachment 10—Other Information (as applicable)	Any additional information to support the application.

SUBMITTING THE APPLICATION

Applications must be submitted electronically through the HRSA Electronic Handbooks (EHB). Refer to HRSA's *Electronic Submission User Guide*, available online at http://bphc.hrsa.gov/about/lookalike/index.html for detailed application and submission instructions.

Annual certification applications are due 90 days prior to the end of the certification period. The HRSA EHB system will send electronic email reminders to the organization's contacts identified in the EHB system 150 days prior to the end of the certification period to inform them the application is accessible in the EHB system. Once notified that the application is available

within the EHB, applicants will have 60 days to complete and submit the annual certification application in the EHB system. Failure to submit the annual certification application could result in termination of the look-alike designation and all corresponding benefits.

Applications will be considered having been formally submitted if the application has been successfully transmitted electronically by your organization's AO through HRSA's EHB.

Applicants must ensure that the AO is available to submit the application before the 60 day application period has ended. HRSA will <u>not</u> accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the 60 day application period.

Refer to HRSA's *Electronic Submission User Guide*, available online at http://bphc.hrsa.gov/about/lookalike/index.html, for detailed application and submission instructions. Applicants must submit applications according to the instructions in this document and the User Guide.

ADDITIONAL INROMATION AND TECHNICAL ASSISTANCE
Look-Alike Annual Certification Application Questions
Technical assistance regarding these instructions may be obtained by contacting the Project Officer assigned to your organization and/or the appropriate Primary Care Association (PCA), Primary Care Office (PCO), or National Cooperative Agreement (NCA). A list of these organizations is available at http://bphc.hrsa.gov/technicalassistance/partnerlinks/index.html.

Additional information related to the Look-Alike Program and/or technical assistance is available at http://bphc.hrsa.gov/about/lookalike/index.html.

For Assistance with Application Submission and the HRSA electronic Handbooks (EHB)
Applicants who need assistance preparing and submitting their application electronically through HRSA's EHB can contact:

BPHC Helpline
Phone: 1-877-974-2742
Email: BPHCHelpline@hrsa.gov

APPENDIX A: Required Forms Instructions

The BPHC Program Specific forms must be completed electronically in the HRSA EHB. To preview the forms, visit http://bphc.hrsa.gov/about/lookalike/index.html. Portions of the forms that are grayed out are not relevant to the application and do not need to be completed.

FORM 1A – General Information Worksheet (Required)
Form 1A provides a summary of information related to the look-alike project.

1. **APPLICANT INFORMATION**
    - Complete all relevant information that is not pre-populated.
    - Applicants may check only one category in the Business Entity section. If an applicant is a Tribal or Urban Indian entity and also meets the definition for a public or private entity, then the Applicant should select the Tribal or Urban Indian category.
    - Applicants may select more than one category for the Organization Type section.

2. **SERVICE AREA**
    2a. Target Population and Service Area Designation
    - Applicants seeking section 330(e) designation for Community Health Centers (CHC) MUST provide Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP) designation information. Select the MUA and/or MUP designations that best describe the service area. For inquiries regarding MUAs or MUPs, call 1-888-275-4772 (option 2) or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816. For additional information, visit the Shortage Designation Web site at http://bhpr.hrsa.gov/shortage.
    - Select the type of designation requested (i.e., section 330(e), section 330(g), section 330(h), and/or section 330(i)). Refer to definitions of the MHC, HCH, and PHPC populations.

    2b. Service Area Type
    - Classify the target population type as Urban, Rural, or Sparsely Populated. To be determined sparsely populated, the entire service area must have seven or fewer people per square mile.

    2c. Target Population Information
    - Applicants with more than one site should report aggregate data for all of the sites included in the look-alike initial designation application.
    - Provide the number of individuals currently composing the service area and target populations.

When providing the count of patients and visits, note the following guidelines (see the 2012 UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services must be documented in the patient's record. Such contacts provided by contractors and paid for by the grantee are considered to be visits.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits. Do not report patients and visits for services outside the organization's scope of project. Specifically, the scope of project defines the service sites, services, providers, service area, and target population for which the look-alike designation applies. For more information, see PIN 2008-01 available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.
- Do not report patients and visits for vision services.

Patients and Visits by Service Type:
- List the current number of unduplicated patients and visits consistent with the 2012 UDS Report within each service type category across all look-alike sites. Within each service type category (medical, dental, behavioral health, substance abuse, and enabling services), an individual can only be counted once as a patient. An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).

Unduplicated Patients and Visits by Population Type:
- Project the number of patients and visits anticipated within each population type category across all look-alike sites by the end of the certification period.
- Data reported for patients and visits should not be duplicated within or across the four target population categories (i.e., General Community, Migratory and Seasonal Agricultural Workers, Public Housing Residents, Homeless Persons).

    NOTE: The Population Type in this table refers to the population being served, not the designation Type (i.e., section 330(g), section 330(h), section 330(i)).

FORM 2 – Staffing Profile (Required)
The Staffing Profile reports personnel salaries supported by the total budget for the project, including those that are part of an indirect cost rate. Include all paid staff for the entire scope of the look-alike project. Anticipated staff changes within the certification period must be addressed in the Resources/Capabilities section of the Program Narrative.
- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Report ONLY portions of salaries that support activities within the look-alike scope of project.
- Do not include contracted or volunteer staff on this form.

The Staffing Profile should be consistent with the amounts for personnel costs included in the budget justification.

FORM 3 – Income Analysis (Required)

Project the program income, by source, for each year of the look-alike certification period by presenting the estimated revenues for the upcoming certification year. Anticipated changes within the upcoming certification period must be addressed in the budget justification. Entries that require additional explanation (e.g., projections that include reimbursement for billable events that UDS does not count as visits) must be discussed in the Comments/Explanatory Notes box and, if necessary, detailed in the budget justification. Form 3 must be based ONLY on the look-alike project.

The two major classifications of revenues are as follows:
The program income section groups billable visits and income into the same five payer groupings used in the Uniform Data System (UDS – see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics for details). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, behavioral health, substance abuse, other professional, vision, and other clinical services as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations which are designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees.

Patient service revenue associated with sites or services not in the approved scope of project including those pending approval is to be excluded.

Column (a) Patients: These are the projected number of unduplicated patients classified by payer based upon the patient's ***primary medical insurance***. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in UDS Table 4, lines 7 – 12. This column should not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Column (b): Billable Visits: These include all billable/reimbursable visits.[4] There may be other exclusions or additions which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy,

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[4] These visits will correspond closely with the visits reported on the UDS Table 5, excluding enabling service visits.

imaging, and other ancillary services are not to be included in this column (see ancillary instructions below).

Column (c): Income per Visit: This is the quotient arrived at by dividing projected income by billable visits.

Column (d): Projected Income: This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the upcoming certification period.

Column (e): Prior FY Income Mo/Yr: This is the income data from the most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

(Lines 1 – 5) Payer Categories: There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings used in Table 9d of the UDS. The UDS instructions are to be used to define each payer category (see the UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics).

Visits are reported on the line of the primary payer (payer billed first). The income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if the applicant cannot accurately associate the income to secondary and subsequent sources.

All service income is to be classified by payer, including pharmacy and other ancillary service revenue. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

(Line 1) Medicaid: This includes income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

(Line 2) Medicare: This includes income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal

intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement, risk pool distributions, performance incentives, and care management fee income from the ACA Medicare Demonstration Program.

(Line 3) Other Public: This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other public also includes income from categorical grant programs when the grant income is earned by providing services. Examples of these include CDC's National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

(Line 4) Private: This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers. Income from health benefit plans which are earned by government employees, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

(Line 5) Self-Pay: This includes income from patients, including full-pay self-pay and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

(Line 6)Total: This is the sum of lines 1-5.

PART 2: OTHER INCOME
This section includes all income other than the patient service revenue shown in Part 1. It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients (patients of an entity with which the health center is contracting) either in-house or under contract with another entity such as a hospital, nursing home or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

(Line 7) Other Federal: This is income from federal grants where the look-alike organization is the recipient of a Notice of Award from a federal agency. It includes grants from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), and others.

(Line 8) State Government: This is income from state government grants, contracts, and programs, including uncompensated care grants; emergency preparedness grants; mortgage assistance; capital improvement grants; school health grants; Women, Infants, and Children (WIC); immunization grants; and similar awards.

(Line 9) Local Government: This is income from local government grants, contracts, and programs, including indigent care grants, community development block grants, capital improvement project grants, and similar awards. For example: (1) a health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A grants would be classified as income earned from a local government and be shown on this line.

(Line 10) Private Grants/Contracts: This is income from private sources such foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

(Line 11) Contributions: This is income from private entities and individual donors which may be the result of fund raising.

(Line 12) Other: This is incidental income not reported elsewhere and includes items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some Other income to report on Line 12.

(Line 13) Applicant (Retained Earnings): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why the applicant funds are needed and provide an assurance that the reserves are sufficient to meet the amount budgeted and that the remaining reserves are adequate to support normal operations.

(Line 14) Total Other: This is the sum of lines 7 – 13.

(Line 15) Total Non-Federal: This is the sum of Lines 6 and 14 and is the total non-federal income.

FORM 3A – Look-Alike Budget Information (Required)
Part 1: Expenses: includes personnel, fringe benefits, travel, equipment, supplies, contractual, construction, and other expenses. Indirect charges may also be included.

For each of the expense categories, enter the next year's expenses for each of the applicable Programs, Functions, or Activities. If the categories in the form do not describe all possible expenses, organizations may enter expenses in the "Other" category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue: includes funds supplied by the applicant and/or Federal, State, local, other sources.

For each of the revenue categories, enter the next year's revenue from each of the applicable Programs, Functions, or Activities. If revenue is collected from sources other than the listed sources, indicate those in the "Other" category. The total fields are calculated automatically as you move through the form.

FORM 5A – Services Provided (Required)

Data will be pre-populated from the look-alike's official scope of project and cannot be modified. HRSA does not allow any change in scope or self-update at the time of the annual certification submission.

A look-alike's approved scope of project includes services on Form 5A. Services identified elsewhere in the application (e.g., Program Narrative) and not identified on Form 5A will not be considered to be in the approved scope of project.

NOTE: If your organization has a pending Change in Scope application to add a service, it will not be included in Form 5A until the Change in Scope has been approved and verified by applicant.

FORM 5B – Service Sites (Required)

Data will be pre-populated from the look-alike's official scope of project. No changes in scope or self-updates are allowed at the time of the annual certification submission.

A look-alike's approved scope of project includes service sites on Form 5B. Sites identified elsewhere in the application (e.g., Program Narrative) and not identified on Form 5B will not be considered to be in the approved scope of project.

FORM 5C – Other Activities/Location (As applicable)

Data will be pre-populated from the look-alike's official scope of project. The form is read-only and may not be modified. This form includes activities/locations that: 1) do not meet the definition of a service site; 2) are conducted on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the approved scope of project. Refer to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes (available at
http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html) for more details.
Information presented on Form 5C is used by HRSA to determine the scope of project for the look-alike. However, regardless of what information is included on Form 5C, only the services included on Form 5A and the service sites included on Form 5B will be considered part of the approved scope of project. Any additional activities/locations described or detailed in other

portions of the application (e.g., narratives, attachments) that are not listed on Form 5C are not considered to be included in the approved scope of project.

FORM 6A – Current Board Member Characteristics (Required)

The data will be pre-populated from the previous annual cerification, renewal of designation or initial designation submission. **Applicants are expected to update pre-populated information as appropriate.**

- Public entities with co-applicant health center governing boards must list the co-applicant board members.
- Applicants requesting a waiver of the 51% patient majority requirement must list the health center's board members, not the members of any advisory councils.
- List the current board office held for each board member, if applicable (e.g., Chair, Treasurer).
- List each board member's area of expertise (e.g., finance, teacher, nursing).
- Indicate if each board member is a health center patient.
- Indicate if each board member lives and/or works in the service area.
- List how long each individual has been on the board.
- Indicate if each board member is a representative of a special population (i.e., homeless, migrant, public housing).
- Classify board members in terms of gender, ethnicity, and race.

NOTE: Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form. When Tribal is selected as the business entity on Form 1A, Form 6A will automatically display as complete. However, such applicants may include information on this form as desired.

FORM 8 – Health Center Agreements (As applicable)

Complete Part I, indicating whether current or proposed agreements constitute a substantial portion of the scope of project. If the applicant has a contract for core primary care providers, non-provider health center staff, chief medical officer (CMO) or chief financial officer (CFO), if a site is operated by a contractor, which must also be identified in Form 5B, or if the applicant otherwise has an agreement to a substantial portion of the scope of project, the answer must be "**Yes**." If "**Yes**," indicate the number of each type in the appropriate field. If "**No**," skip to the Governance Checklist in Part II.

Complete the Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be "**Yes**," and the number of such agreements/arrangements must be indicated. Additionally, "**No"** responses for the Governance Checklist must be explained in the Resources/Capabilities section of the Program Narrative.

Part III should be completed only by applicants that responded "**Yes"** to Part I.1 or Part II.2. In Part III, use the Organization Agreement Details section to provide the contact information for each organization (up to 10) with which an agreement/arrangement either (1) constitutes a substantial portion of the scope of project (as described in Part I) or (2) impacts the governing board's composition, authorities, functions, or responsibilities (as described in Part II). **Upload each agreement/arrangement** (up to 5) in full. Agreements/arrangements that exceed these limits should be included in Attachment 10—Other Attachments.

NOTE: Attachment 3—Affiliation, Contract and/or Referral Agreements must include a comprehensive list and summary of each arrangement, contract, and affiliation agreement, including those which are also discussed and attached in full as part of Form 8—Health Center Agreements.

Form 10 – Annual Emergency Preparedness Report (Required)
Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in the Resources/Capabilities section of the Program Narrative. This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

Form 12 – Organizational Contacts (Required)
Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

APPENDIX B: Required Attachments Instructions

To ensure that attachments are organized and printed in a consistent manner, follow the order provided below.
- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment).
- Merge similar documents (e.g., Letters of Support) into a single document. Add a table of contents page specific to the attachment.
- Limit file names for attachments to 100 characters or less. Attachments will be rejected by EHB if file names exceed 100 characters.
- **If the attachments marked "required for completeness" are not uploaded, the application will be considered incomplete and non-responsive, thereby making it ineligible.**

Attachment 1—Service Area Map (Required)
Maps should be created using HRSA's UDS Mapper located at http://www.udsmapper.org.
Upload a map of the service area for the project which clearly identifies:
1. The areas (e.g., zip codes or census tracts) served by the organization.
2. Each service delivery site listed in Form 5B: Service Sites.
3. Designated medically underserved areas (MUAs) and/or medically underserved populations (MUPs).
4. All Health Center Program grantees in the service area.
5. All Health Center Program look-alikes in the service area.
6. Other health care providers serving the same population(s), e.g., free clinics, rural health centers, etc.
7. The UDS data that complements the information provided in the map.

PLEASE NOTE: You will have to manually place markers for the locations of other major private provider groups serving low income/uninsured populations.

Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of Health Center Program grantees serving each ZCTA, the dominant grantee serving the ZCTA and its share of Health Center Program patients, total population, total low-income population, total Health Center Program grantee patients, and patient penetration levels for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper when the map is created. See http://www.hrsa.gov/grants/apply/assistance/sac for samples and instructions on creating maps using UDS Mapper. For a tutorial on how to create a map, see How To: Create a Service Area Map and Data Table at http://www.udsmapper.org/tutorials.cfm.

Attachment 2—Governing Board Bylaws (As applicable)
If there are changes to the governing board bylaws, provide a signed and dated copy. The bylaws must demonstrate compliance with the board authority, composition, conflict of

interest and all other requirements of section 330 of the PHS Act, 42 C.F.R. 51c, and 42 C.F.R. 56 (as applicable).

Attachment 3—Affiliation, Contract, and/or Referral Agreements (As applicable)

Attachment 3—Affiliation, Contract and/or Referral Agreements must include a comprehensive list and summary of each arrangement, contract, and affiliation agreement, including those which are also discussed and attached in full as part of Form 8—Health Center Agreements. Indicate with an asterisk (*) agreements in Attachment 3 that are also attached in full as part of Form 8—Health Center Agreements.

Applicants that do not have contractual agreements with another entity should clearly indicate so in the narrative. As a reminder, contracts must be in compliance with section 330 of the PHS Act and 42 C.F.R. 51c.

Contracts for Provision of Required Services

Summaries of contracts for required services (i.e., services indicated in Form 5A—Services Provided, Column 2) must include:
1. Name and contact information for each affiliated agency.
2. Brief description of the purpose and scope of each contract or (i.e., type of services to be provided, how/where services will be provided, how the health center will reimburse costs of care).
3. Timeframe for each agreement/contract.

Formal Referral Arrangements for Provision of Required Services

Summaries of formal referral arrangements (i.e., services indicated in Form 5A—Services Provided, Column 3) must include:
1. Name and contact information for each affiliated agency
2. Brief description of the purpose and scope of each contract or (i.e., type of services to be provided, how/where services will be provided).
3. How services will be provided on a sliding fee scale compliant with Health Center Program requirements.
4. How the referred visit will be documented in the patient record and follow up care will be assured at the referring health center.

Other Contracts and Affiliation Agreements

Summaries of other contracts (i.e., contracts or affiliations for management and other services not included on Form 5A—Services Provided) must include:
1. Name and contact information for each affiliated agency.
2. Brief description of the purpose and scope of each contract or (i.e., type of services to be provided, how/where services will be provided, how the health center will reimburse costs of care).
3. Timeframe for each contract/affiliation.

NOTE: All affiliation, contract, and referral agreements must be available for submission to HRSA by request.

NOTE: In Form 8—Health Center Agreements, applicants must note and attach in full all contracts that make up a substantial scope of project, e.g., contracting for core primary care providers, non-provider health center staff, chief medical officer (CMO) or chief financial officer (CFO), if a site is operated by a contractor, or if the applicant has an agreement that otherwise constitutes a substantial portion of the scope of project. These agreements must also be summarized in Attachment 3—Affiliation, Contract and/or Referral Agreements.

Attachment 4—Organizational Chart (As applicable)

If there are changes to the organizational and management structure, provide an updated organizational chart indicating lines of authority. The chart must include:
- Key employee position titles
- Names
- Full-time equivalents (FTEs) of each individual. Provide a justification for any part-time or shared positions in the Program Narrative.

Clearly identify each individual with the following responsibilities:
- CEO/Executive Director
- Chief Medical Officer (CMO)/Clinical Director
- Chief Financial Officer (CFO)/Financial Manager
- Other key management staff, e.g., Chief Operations Officer (COO)

The chart should demonstrate that the governing board retains ultimate authority and leadership of the organization.

Public entities with co-applicant arrangements should demonstrate the relationship between the two organizations and the co-applicants' relationships to the health center.

Attachment 5—Position Descriptions for Key Personnel (As applicable)

Submit a copy of position descriptions for all key management positions if there have been changes. Indicate if key management positions are shared and/or part-time (e.g., chief financial officer (CFO) and chief operation officer (COO) roles are shared). At minimum, position descriptions should include:
- Position title
- Description of duties and responsibilities
- Position qualifications, supervisory relationships
- Skills, knowledge and experience requirements
- Travel requirements
- Salary range
- Hours worked

Attachment 6—Resumes for Key Personnel (As applicable)

If there have been changes to key personnel for the organization, provide copies of their resumes. If a resume is included for an identified individual who is not yet hired, include a letter of commitment from that person along with the resume.

Attachment 7—Most Recent Independent Financial Audit (Required)

Applicants in operation for more than one year

Submit a complete copy of the organization's most recent annual audit, including the auditor's opinion statement (i.e., management letter). Audit information must include the balance sheet, profit and loss statement, audit findings, and any noted exceptions. The audit must comply with generally accepted accounting principles (GAAP). In instances where the audit is not available at the time of application submission, identify the anticipated time frame for completion of the auditor report and submit a copy of the organization's most recent six months of financial statements.

Attachment 8—Schedule of Discounts/Sliding Fee Scale (Required)

Provide a schedule of charges with a corresponding schedule of discounts for which charges are adjusted on the basis of the patient's ability to pay. Applicants must show sliding fee scale discounts for persons with incomes between 200% and 100% of the most current annual Federal poverty guidelines (FPG) (see the most current annual FPG at http://aspe.hhs.gov/poverty/). Patients with incomes below 100 percent of the FPG may not be charged for services (nominal fees are acceptable if they are not barriers to obtaining services). No discounts may be given to patients with incomes over 200% of the FPG.

Attachment 9—Budget Narrative (Required)

Provide a detailed budget justification in line-item format for **the 12-month period**. **An itemization of revenues and expenses is necessary for the year of the budget justification.** Attach the budget justification in the Budget Narrative Attachment Form section in EHB. The budget justification must be concise and should not be used to expand the Program Narrative. Please be aware that Excel or other spreadsheet documents with multiple pages (sheets) may not print out in their entirety.

Attachment 10—Other Information (As applicable)

Include other relevant documents to support the project plan.

APPENDIX C: Clinical and Financial Performance Measures Instructions

The clinical and financial performance measures are ongoing performance improvement tools that provide a summary of a look-alike's PROGRESS towards the goals that were identified in their most recently approved application. The Clinical and Financial Performance Measures Forms should outline time-framed and realistic goals and related performance measures (as referenced below) with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization, including multiple sites and/or various activities at multiple sites.

Important Details about the Clinical and Financial Performance Measures
In the Clinical and Financial Performance Measures Forms for Calendar Year 2013 annual certification applications, look-alike organizations will need to manually type in the goals they listed in their most recently approved initial designation or renewal of designation application. Look-alikes should then provide progress toward the goals for each performance measure identified in their most recently approved look-alike application.

A Designation Period end goal can be revised if major accelerated progress or barriers have been experienced in the previous annual certification period. The rationale and comments for any revisions must be provided in the comments sections and/or the Program Narrative, as applicable.

The comments section for each performance measure is an open text field where look-alikes are expected to provide information regarding their progress toward the performance measure goal. The comments section has a 1,000 character limit. Look-alikes are encouraged to use the Evaluative measures section of the Program Narrative to include any additional comments from the clinical and financial performance measures comment fields that exceed the character limit.

Organizations are expected to integrate the health center performance measures within each Need/Focus Area identified below, as appropriate. The health center performance measures are accessible on HRSA's Web site at
http://bphc.hrsa.gov/policiesregulations/performancemeasures/. Additional information on the clinical performance measures can be found in the annual Uniform Data System Reporting Manual available at http://bphc.hrsa.gov/uds/. Additional technical assistance related to the clinical and financial performance measures is available through HRSA and the State PCA.

Applicants are required to report prenatal and perinatal performance measures. Please refer to Program Assistance Letter 2013-07 located at
http://bphc.hrsa.gov/policiesregulations/policies/pal201307.html. Applicants reporting these measures for the first time can enter 0 for the baseline data and provide a date by which baseline data will be gathered. The projected data field must be completed with a predicted three-year goal (estimates are acceptable).

Applicants designated to target special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), ***must include*** additional performance measures that address the health care needs of these populations. In providing additional performance measures specific to a special population, applicants must reference the target group in the performance measure. For example, if an applicant seeks funds to serve migratory and seasonal agricultural workers, then the applicant must propose to measure *"the percentage of migratory and seasonal agricultural workers who…"* ***rather than*** simply *"the percentage of patients who…"*.

Applicants that have identified other unique issues (e.g., populations, age groups, health issues, risk management efforts) in the Need section of the Program Narrative, they are encouraged to include additional related performance measures.

All performance measures must include a numerator and denominator that can be tracked over time.

Any additional narrative regarding the clinical and financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

Special Instructions for Existing Performance Measures
Report the **Diabetes Clinical Performance Measure** as follows:
- Report adult patients with HbA1c levels ≤ 9 percent in the Baseline Data (numerator and denominator subfields) and Projected Data fields.
- If desired, report the additional measurement thresholds (i.e., < 7 percent, < 8 percent, > 9 percent) in the Comments field.

The **Child Health Performance Measure** has been modified to include the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate vaccines by age 3.

The **Cancer Screening Performance Measure** has been modified to include the following: Number of female patients age 24 - 64 years of age who received one or more documented Pap tests during the measurement year or during the two years prior to the measurement year OR, for women over 30, received a Pap test accompanied with an HPV test done during the measurement year or the four years prior who had at least one medical visit during the reporting year.

Applicants must address the performance measures provided by HRSA in their Clinical and Financial Performance Measures Forms, as applicable. All applicants are expected also include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the Clinical Performance Measures Form. (Please visit http://bphc.hrsa.gov/policiesregulations/performancemeasures/ to view the HRSA performance measures.)

Applicants may also wish to consider utilizing Healthy People 2020 goals and performance measures when developing their clinical and financial performance measures. Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The program consists of 41 focus areas and more than 1,400 objectives. Further information on Healthy People 2020 goals may be downloaded at http://www.healthypeople.gov/document/.

NOTE: Look-alikes that have not yet submitted a renewal of designation application with three-year Clinical and Financial Performance Measures Forms must do so in this annual certification application. Organizations should contact the assigned Project Officer for additional guidance.

Need Addressed/Focus Area
This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population and/or organization to be addressed (Diabetes; Cardiovascular Disease; Costs, Productivity, etc.). Applicants are expected to address each required performance measurement area (as described in the table below), as well as any other key needs of their target population or organization as identified in the application narrative.

Designation Period Goal(s) with Baseline
Goals are relatively broad statements relating to the Need Addressed/Focus Area. Applicants should provide goals which, where possible, can be accomplished by the end of the multi-year designation period. The goal should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide baseline data (where possible) to indicate their status at or prior to the beginning of the designation period. Note that for some look-alikes this may mean several years ago. But for look-alikes in the first year of a new designation period, it will mean the value of the most recent reporting year. Baseline data provides a basis for quantifying the amount of growth/change to be accomplished in the designation period. If applicants choose to establish a baseline for any of the new clinical performance measures, they are encouraged to utilize the sampling/chart review instructions provided in the 2009 Uniform Data System Reporting Manual, available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2009udsreportingmanual.pdf. Applicants are expected to track performance against these goals throughout the entire approved designation period and to report progress achieved on the goal in this and subsequent annual certification applications. However, designation period end goals can be revised if major accelerated progress or barriers have been experienced in the previous certification period. The rationale and comments for any revisions must be provided in the Progress towards Goal section of the Clinical and Financial Performance Measures Forms and/or Program Narrative, as applicable.

Applicants that included additional goals and performance measures in their most recent initial/renewal of designation application must also report progress on these goals. In cases where data on the new clinical performance measures was not previously collected by the organization, these should be listed as "Data Not Available."

Progress Towards Goal (Report 3-Year Trend—Quantitative)
Report quantitative progress on the related performance measures, including all required measures, stated in the applicant's most recent application. Applicants should report progress in terms of trends (e.g., % increase or decrease) based on the most recent three-years of complete data if such data are available. Additional measures chosen by the applicant should also define the numerator and denominator[5] that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Progress Towards Goal (Qualitative)
Describe qualitative progress, such as major processes, strategies or objectives achieved to date that contribute to the achievement of the goal. Also, include any significant changes in the contributing and/or restricting factors impacting the look-alike's performance on the measure as well as any significant changes in the key actions or major planned responses to these factors.

NOTE: Detailed narrative regarding contributing or restricting factors affecting progress on the clinical or financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

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[5] When used here, "denominator" means the universe of patients who fit the criteria. It is assumed that most look-alikes will measure these ratios by using a scientifically drawn sample.

SAMPLE MEASURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Designation Period Date	01/01/2014 - 12/31/2017

Focus Area: Diabetes		
Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent		
Is this Performance Measure Applicable to your Organization?	Yes	
Target Goal Description	By the end of the Designation Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%	
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.	
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria	
Baseline Data	**Baseline Year:** 2009 **Measure Type:** Percentage **Numerator:** 2200 **Denominator:** 4000	Projected Data (by End of Designation Period) / 65%
Data Source & Methodology	Representative sample of patient records. (Data run on 1/10/2010)	
Key Factor and Major Planned Action #1	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** XYZ offers a variety of pharmaceutical assistance programs, including the provision of free, discounted, or generic medications as well as medications through its 340B Federal Drug Pricing arrangement. At least 70% of diabetic patients are on 3 to 8 medications because of co-morbidity complications that occur. **Major Planned Action Description:** Increase education and outreach efforts to diabetic patients on the importance of daily testing and the availability of free/discounted glucometers and test strips available through XYZ.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Designation Period Date	01/01/2014 - 12/31/2017

Key Factor and Major Planned Action #2	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** XYZ has an agency-wide, multidisciplinary team that includes physicians, nurses, medical assistants, a quality management coordinator and a data specialist. The team works with each site to analyze and improve the internal processes to achieve effective diabetes care delivery. **Major Planned Action Description:** At each site, XYZ will identify a physician champion who will be allotted administrative time to work with fellow staff to test and implement changes. The agency-wide and site-specific teams will form a collaborative infrastructure that provides diabetic patients with the necessary tools and support to successfully manage their disease.
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [x] Restricting [_] Not Applicable **Key Factor Description:** Time management becomes problematic when XYZ staff juggles regular work with Diabetes Collaborative tasks. The agency-wide team would like to meet more frequently, but providers are pressed for administrative time given their full clinical schedules. Any type of backlog or deficiency adds system stress to a provider or staff member's work schedule that negatively affects patient care management. **Major Planned Action Description:** Hire an additional clinical staff person to provide additional "non-clinical" review time for the agency-wide team members.
Progress Toward Goal	**Quantitative:** 53.6%
	Qualitative: We had an 11% improvement in performance on this measure compared to our baseline and are well on our way to addressing our goal of 65% by the end of the designation period. The main contributor to our success this year was the implementation of physician champions across all of our sites who allotted administrative time to work with fellow staff to test and implement changes to our diabetes management protocols. The agency-wide and site-specific teams formed a collaborative infrastructure that provided diabetic patients with the necessary tools and support to successfully manage their disease. We plan to continue our work with the physician champions and further improve performance by developing an incentive plan that rewards providers to improve their patients' health outcomes.
Comments	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration**	Organization Name	Application Tracking Number
	XYZ Health Center	00000
SAMPLE CLINICAL PERFORMANCE MEASURE	Designation Period Date	01/01/2014 - 12/31/2017

Focus Area: Costs		
Performance Measure: Medical Cost per Medical Visit		
Is this Performance Measure Applicable to your Organization?	Yes	
Progress Toward Goal	By the end of the Designation Period, maintain rate of increase not exceeding 5% per year, such that medical cost per medical visit is less than or equal to 164.83.	
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)	
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)	
Baseline Data	**Baseline Year:** 2009 **Measure Type:** Ratio **Numerator:** 492000 **Denominator:** 4000	Projected Data (by End of Designation Period) 164.83
Data Source & Methodology	UDS	
Key Factor and Major Planned Action #1	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** Recent addition of nurse practitioner providers increased XYZ encounters. **Major Planned Action Description:** Continue assessing current patient/provider mix to best utilize resources.	
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [X] Restricting [_] Not Applicable **Key Factor Description:** Recently lost our pediatrician to a local competitor, therefore child visits are down. **Major Planned Action Description:** We are beginning efforts to recruit a NHSC loan repayor to address the shortage.	
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:**	

		FOR HRSA USE ONLY	
DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration**		Organization Name	Application Tracking Number
		XYZ Health Center	00000
SAMPLE CLINICAL PERFORMANCE MEASURE		Designation Period Date	01/01/2014 - 12/31/2017
	Major Planned Action Description:		
Progress Toward Goal	**Quantitative:** 127.01		
	Qualitative: We experienced a 3.3% increase in our medical cost per medical visit. During the middle of the year we were able to hire a nurse practitioner who works in two of our sites. The addition of the nurse practitioner has increased the overall number of medical visits to the health center. We plan to continue to review our staffing mix to ensure we are staffed in a manner that maximizes our productivity and supports our goal of cost increases minimal.		
Comments			